		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032862

Facility Name: DANVILLE CARE CENTER

Address: 1701 N. BOWMAN AVE (Number) DANVILLE (City) 61832 (Zip Code)

County: VERMILLION

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-3532095

Date of Initial License for Current Owners: 10/1/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,371	4,371	8
9	SNF/PED					9
10	ICF	36,881	4,384	1,352	42,617	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,881	4,384	5,723	46,988	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.37%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 4,371

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	227,792	9,772	9,809	247,373		247,373		247,373			1
2	Food Purchase		201,572		201,572		201,572	(791)	200,781			2
3	Housekeeping	171,071	45,336		216,407		216,407	559	216,966			3
4	Laundry	111,026	25,143	131	136,300		136,300		136,300			4
5	Heat and Other Utilities			139,819	139,819		139,819		139,819			5
6	Maintenance	39,630	48,431	44,866	132,927		132,927	97	133,024			6
7	Other (specify):*			8,815	8,815		8,815		8,815			7
8	**TOTAL General Services**	549,519	330,254	203,440	1,083,213		1,083,213	(135)	1,083,078			8
	B. Health Care and Programs											
9	Medical Director			8,030	8,030		8,030		8,030			9
10	Nursing and Medical Records	1,707,119	126,515	237,549	2,071,183		2,071,183	23,069	2,094,252			10
10a	Therapy	122,633	312	1,589	124,534		124,534		124,534			10a
11	Activities	66,767	1,095	615	68,477		68,477		68,477			11
12	Social Services	107,941		5,894	113,835		113,835		113,835			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,004,460	127,922	253,677	2,386,059		2,386,059	23,069	2,409,128			16
	C. General Administration											
17	Administrative	62,170		60,440	122,610		122,610	(4,598)	118,012			17
18	Directors Fees											18
19	Professional Services			88,683	88,683		88,683	(41,251)	47,432			19
20	Dues, Fees, Subscriptions & Promotions			16,208	16,208		16,208	(4,096)	12,112			20
21	Clerical & General Office Expenses	182,731	29,688	185,150	397,569		397,569	(83,086)	314,483			21
22	Employee Benefits & Payroll Taxes			490,770	490,770		490,770	30,703	521,473			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,709	2,709		2,709	3,749	6,458			24
25	Other Admin. Staff Transportation			13,186	13,186		13,186	7,328	20,514			25
26	Insurance-Prop.Liab.Malpractice			138,186	138,186		138,186	3,184	141,370			26
27	Other (specify):*			55,290	55,290		55,290	(55,290)				27
28	**TOTAL General Administration**	244,901	29,688	1,050,622	1,325,211		1,325,211	(143,357)	1,181,854			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,798,880	487,864	1,507,739	4,794,483		4,794,483	(120,423)	4,674,060			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DANVILLE CARE CENTER **#0032862** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,120	
	REPAIRS & MAINTENANCE		689	
			0	9,809
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		131	
			0	131
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,689	
	ELECTRICITY		76,464	
	WATER		32,666	
	CABLE TV - LOBBY		0	
			0	139,819
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		17,346	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		22,958	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,870	
	FIRE SERVICE		2,692	
			0	
			0	
			0	44,866
7	**OTHER**			
	SCAVENGER		8,815	
	SECURITY SERVICE		0	8,815
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,030	8,030

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	218,446	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		15,687	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,016	
	PHARMACY CONSULTANT	XVIII B 39-2	2,400	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	237,549
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	775	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	463	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	351	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,589
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	615	
			0	615
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,894	
			0	5,894
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DANVILLE CARE CENTER **#0032862** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	60,440	60,440
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,529	
	ADMINISTRATIVE CONSULTANTS	XIX C	43,323	
	PROFESSIONAL FEES	XIX C	36,831	
			0	88,683
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,613	
	EMPLOYEE WANT ADS	XIX F	8,838	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	1,097	
	LICENSES & PERMITS	XIX F	2,135	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,375	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	16,208
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		425	
	OUTSIDE CLERICAL SERVICES		154,330	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,557	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		305	
	TELEPHONE		18,773	
	MESSENGER SERVICE		2,760	
				185,150

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	211,196	
	UNEMPLOYMENT COMPENSATION	XIX D	61,484	
	WORKERS COMPENSATION INSURANCI	XIX D	116,153	
	HOSPITALIZATION INSURANCE	XIX D	97,239	
	EMPLOYEE BENEFITS - OTHER	XIX D	70	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	4,628	
	CHICAGO HEAD TAX	XIX D	0	490,770
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,577	
	TRAVEL	XIX G	1,132	
			0	
			0	2,709
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,186	13,186
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		138,186	138,186
27	**OTHER**			
	BAD DEBTS	VI 24	55,290	
			0	55,290

GRAND TOTAL COLUMN 3 OTHER 1,507,739

Facility Name & ID Number DANVILLE CARE CENTER #0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			68,271	68,271		68,271	191,192	259,463			30
31	Amortization of Pre-Op. & Org.							26,667	26,667			31
32	Interest			14,435	14,435		14,435	527,422	541,857			32
33	Real Estate Taxes			61,214	61,214		61,214		61,214			33
34	Rent-Facility & Grounds			803,285	803,285		803,285	(793,373)	9,912			34
35	Rent-Equipment & Vehicles			13,032	13,032		13,032	513	13,545			35
36	Other (specify):*											36
37	**TOTAL Ownership**			960,237	960,237		960,237	(47,579)	912,658			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,220	22,126	151,346		151,346		151,346			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		129,220	131,626	260,846		260,846		260,846			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,798,880	617,084	2,599,602	6,015,566		6,015,566	(168,002)	5,847,564			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,339	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(791)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(8,557)	21		18
19	Entertainment		20		19
20	Contributions	(1,525)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,290)	27		24
25	Fund Raising, Advertising and Promotional	(2,613)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(36,769)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,206)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(70,796)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (70,796)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (168,002)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DANVILLE CARE CENTER

ID# 0032862

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING	$ (36,769)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(36,769)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(791)	0	0	0	0	0	0	0	0	0	0	(791)	2
3	Housekeeping	0	0	559	0	0	0	0	0	0	0	0	559	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	97	0	0	0	0	0	0	0	0	97	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(791)	0	656	0	0	0	0	0	0	0	0	(135)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	23,069	0	0	0	0	0	0	0	0	23,069	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	23,069	0	0	0	0	0	0	0	0	23,069	16
	C. General Administration													
17	Administrative	0	(60,440)	55,842	0	0	0	0	0	0	0	0	(4,598)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(43,323)	2,072	0	0	0	0	0	0	0	0	(41,251)	19
20	Fees, Subscriptions & Promotions	(4,138)	0	42	0	0	0	0	0	0	0	0	(4,096)	20
21	Clerical & General Office Expenses	(45,326)	(154,193)	116,433	0	0	0	0	0	0	0	0	(83,086)	21
22	Employee Benefits & Payroll Taxes	0	0	30,703	0	0	0	0	0	0	0	0	30,703	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,749	0	0	0	0	0	0	0	0	3,749	24
25	Other Admin. Staff Transportation	0	0	7,328	0	0	0	0	0	0	0	0	7,328	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,184	0	0	0	0	0	0	0	0	3,184	26
27	Other (specify):*	(55,290)	0	0	0	0	0	0	0	0	0	0	(55,290)	27
28	**TOTAL General Administration**	(104,754)	(257,956)	219,353	0	0	0	0	0	0	0	0	(143,357)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(105,545)	(257,956)	243,078	0	0	0	0	0	0	0	0	(120,423)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,339	179,449	3,404	0	0	0	0	0	0	0	0	191,192	30
31	Amortization of Pre-Op. & Org.	0	26,667	0	0	0	0	0	0	0	0	0	26,667	31
32	Interest	0	527,422	0	0	0	0	0	0	0	0	0	527,422	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(803,285)	9,912	0	0	0	0	0	0	0	0	(793,373)	34
35	Rent-Equipment & Vehicles	0	0	513	0	0	0	0	0	0	0	0	513	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,339	(69,747)	13,829	0	0	0	0	0	0	0	0	(47,579)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(97,206)	(327,703)	256,907	0	0	0	0	0	0	0	0	(168,002)	45

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED				CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
				MANAGEMENT		MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 60,440	CERTIFIED HEALTH MANAGEMENT		$	$ (60,440)	1
2	V	21	BOOKKEEPING	154,330				(154,330)	2
3	V	19	ADMIN CONSULTING FEES	43,323				(43,323)	3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	803,285	DANVILLE CARE CENTER LLC			(803,285)	7
8	V	30	DEPRECIATION		" " "		179,449	179,449	8
9	V	31	AMORTIZATION		" " "		26,667	26,667	9
10	V	32	INTEREST		" " "		527,422	527,422	10
11	V	21	OFFICE EXP		" " "		137	137	11
12	V								12
13	V								13
14	Total			$ 1,061,378			$ 733,675	$ * (327,703)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 559	$ 559	15
16	V	5	ELECTRIC & GAS		" " "				16
17	V	6	MAINTENANCE		" " "		97	97	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		23,069	23,069	18
19	V	17	ADMIN SALARIES		" " "		55,842	55,842	19
20	V	19	PROFESSIONAL FEES		" " "		2,072	2,072	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		42	42	21
22	V	21	OFFICE EXP.		" " "		116,433	116,433	22
23	V	22	EMPLOYEE BENEFITS		" " "		30,703	30,703	23
24	V	24	TRAVEL/SEMINAR		" " "		3,749	3,749	24
25	V	25	TRANSPORTATION		" " "		7,328	7,328	25
26	V	26	INSURANCE		" " "		3,184	3,184	26
27	V	30	DEPRECIATION		" " "		3,404	3,404	27
28	V	32	INTEREST		" " "				28
29	V	34	OFFICE RENT		" " "		9,912	9,912	29
30	V	35	EQUIPMENT RENTAL		" " "		513	513	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 256,907	$ * 256,907	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SEE ATTACHED SCHEDULE			SALARY	$ 52,696	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,696		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUTIE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	252,049	8	$ 3,000	$	46,988	$ 559	1
2	5	ELECTRIC & GAS	" " "	252,049	8	0		46,988	0	2
3	6	MAINTENANCE	" " "	252,049	8	520		46,988	97	3
4	10	NURSING/MEDICAL RECORDS	" " "	252,049	8	123,747	123,747	46,988	23,069	4
5	17	ADMIN SALARIES	" " "	252,049	8	299,543	299,543	46,988	55,842	5
6	19	PROFESSIONAL FEES	" " "	252,049	8	11,116		46,988	2,072	6
7	20	FEE, SUBSCRIPTIONS	" " "	252,049	8	225		46,988	42	7
8	21	OFFICE EXP.	" " "	252,049	8	624,560	542,222	46,988	116,433	8
9	22	EMPLOYEE BENEFITS	" " "	252,049	8	164,697		46,988	30,703	9
10	24	TRAVEL/SEMINAR	" " "	252,049	8	20,108		46,988	3,749	10
11	25	TRANSPORTATION	" " "	252,049	8	39,310		46,988	7,328	11
12	26	INSURANCE	" " "	252,049	8	17,081		46,988	3,184	12
13	30	DEPRECIATION	" " "	252,049	8	18,257		46,988	3,404	13
14	32	INTEREST	" " "	252,049	8	0		46,988	0	14
15	34	OFFICE RENT	" " "	252,049	8	53,167		46,988	9,912	15
16	35	EQUIPMENT RENTAL	" " "	252,049	8	2,754		46,988	513	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,378,085	$ 965,512		$ 256,907	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DANVILLE CARE CENTER LLC
Street Address: 3856 OAKTON ST, SUTIE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 179,449	$	1	$ 179,449	1
2	31	AMORTIZATION		1	1	26,667		1	26,667	2
3	32	INTEREST		1	1	527,422		1	527,422	3
4	21	OFFICE EXP		1	1	137		1	137	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 733,675	$		$ 733,675	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BARRY KIRSCHEMBAUM	X		MORTGAGE	$52,439.00	1/1/98	$ 6,300,000	$ 5,852,379	1/1/23	8.9000	$ 527,422	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				544,696		PRIME+	12,519	6
7	AICC		X	INS FINANCING							1,916	7
8												8
9	TOTAL Facility Related				$52,439.00		$ 6,300,000	$ 6,397,075			$ 541,857	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,300,000	$ 6,397,075			$ 541,857	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 61,735	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 60,866	2
3. Under or (over) accrual (line 2 minus line 1).		$ (869)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 62,083	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 61,214	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	51,543	8
1999	57,848	9
2000	59,372	10
2001	60,524	11
2002	60,866	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DANVILLE CARE CENTER COUNTY VERMILLION

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-33-200-016-0060	NURSING HOME	$ 36,567.00	$ 36,567.00
2.	18-34-100-005-0060	NURSING HOME	$ 24,299.00	$ 24,299.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,866.00	$ 60,866.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1998		$ 2,954,225	$ 152,666		$ 152,666	$	$ 916,002	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1989	34,167	1,085	30	1,139	54	15,650	9
10	LEASEHOLD IMPROVEMENTS			1990	17,344	551	30	578	27	7,600	10
11	LEASEHOLD IMPROVEMENTS			1991	45,376	1,441	30	1,513	72	18,444	11
12	LEASEHOLD IMPROVEMENTS			1992	12,043	382	30	401	19	4,507	12
13	LEASEHOLD IMPROVEMENTS			1993	9,213	236	30	307	71	2,914	13
14	LEASEHOLD IMPROVEMENTS			1994	8,304	213	39	213	(0)	2,033	14
15	NURSING STATION			1995	14,331	367	39	367	0	3,044	15
16	DOOR/LIGHT FIXTURES			1995	17,592	451	39	451	0	3,739	16
17	FIRE ALARM & ELECTRICAL WORK			1995	2,420	62	39	62	0	514	17
18	SHOWER/BATH CONST.			1995	4,704	121	39	121	(0)	1,003	18
19	NURSECALL REPAIR			1996	1,655	42	39	42	0	340	19
20	SMOKE DETECTORS/LIGHT FIXTURES/DOOR			1996	5,894	151	39	151	0	1,174	20
21	RESURFACE PARKING AREA			1996	12,910	861	15	861	(0)	6,447	21
22	ROOF REPAIR			1966	12,742	327	39	327	(0)	2,330	22
23	WARDROBE UNITS			1996	8,361	214	39	214	0	1,507	23
24	FLOORING			1996	2,444	63	39	63	(0)	443	24
25	CARPET/WALLPAPER/BUMPER GUARDS/COVE BASE			1997	19,014	488	39	488	(0)	3,210	25
26	PARKING LOT REPAIR			1997	1,500	100	15	100		650	26
27	PAVILION CONST.			1997	8,297	213	39	213	(0)	1,418	27
28	THERAPY ROOM ADDITION			1998	320,230	8,211	39	8,211	0	41,398	28
29	NORTH WING RENOVATION			1998	65,143	1,670	39	1,670	0	8,420	29
30	BUMPER GUARDS			1998	9,285	238	39	238	0	1,419	30
31	CEILING REPAIR/DRYWALL/TILE			1999	17,083	438	39	438	0	1,794	31
32	NURSE CALL/FIRE ALARM SYSTEM			1999	5,616	144	39	144		656	32
33	ROOF REPAIR/AIR EXHAUSTS			1999	7,095	182	39	182	(0)	832	33
34	LANDSCAPING			1999	12,535	836	15	836	(0)	3,761	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	2000	$ 3,436	$ 491	7	$ 491	$ (0)	$ 1,240	37
38	CARPET/COVE BASE/WALLPAPER	2000	9,734	1,391	7	1,391	(0)	3,512	38
39	BATHROOM REPAIR/REMODEL	2000	11,104	404	27.5	404	(0)	1,522	39
40	HOT TUB ROOM REPAIR/REMODEL	2000	6,700	244	27.5	244	(0)	914	40
41	ALARMA SYSTEM/DOORS/CAMERAS	2000	15,171	552	27.5	552	(0)	2,074	41
42	NORTH WING RENOVATION	2000	4,809	175	27.5	175	(0)	653	42
43	WATER HEATER VALVE	2000	1,026	37	27.5	37	0	143	43
44	SECURITY DOOR	2001	693	25	27.5	25	0	62	44
45	WATER HEATER	2001	684	25	27.5	25	(0)	61	45
46	ROOF REPAIRS	2002	10,000	364	27.5	364	(0)	409	46
47	CONCRETE REPAIRS	2002	1,592	58	27.5	58	(0)	66	47
48	ROOF	2003	23,000	383	27.5	383		383	48
49	BEDROOM CEILING/WALLS	2003	3,300	55	27.5	55		55	49
50	BLINDS	2003	3,118	624	5	624	(0)	624	50
51	VENT TO ROOF	2003	5,700	95	27.5	95		95	51
52	INSTALL PULL STATIONS	2003	1,033	17	27.5	17		17	52
53	ELECTRIC DOOR HOLDER/CLOSER	2003	852	14	27.5	14		14	53
54	GAS/ELECT ROOF TOP UNIT	2003	6,542	109	27.5	109		109	54
55	WATER HEATER REPAIR	2003	1,971	33	27.5	33		33	55
56	REPLACE DOORS/EXIT DEVICES	2003	13,040	217	27.5	217		217	56
57	NURSE CALL SYSTEM	2003	9,000	150	27.5	150		150	57
58	HEAT/COOL ROOF TOP UNIT	2003	5,287	88	27.5	88		88	58
59	DURO LAST ROOFING SYSTEM	2003	41,750	696	27.5	696		696	59
60	REPAIR CEILING/DOORS	2003	8,000	133	27.5	133		133	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,817,065	$ 178,133		$ 178,373	$ 240	$ 1,064,516	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 301,515	$ 33,189	$ 44,669	$ 11,480	5-7 YRS	$ 153,983	71
72	Current Year Purchases	18,535	7,092	1,854	(5,239)	5	1,854	72
73	Fully Depreciated Assets	229,001					229,001	73
74	RELATED PARTY ALLOCATION		30,186	30,186				74
75	TOTALS	$ 549,051	$ 70,467	$ 76,708	$ 6,241		$ 384,838	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT DEPT	1995 DODGE VAN	1994	$ 19,595	$	$	$		$	76
77	PATIENT TRANSP	1996 FORD WAGON	2000	21,907	2,524	4,381	1,857	5	20,153	77
78										78
79										79
80	TOTALS			$ 41,502	$ 2,524	$ 4,381	$ 1,857		$ 20,153	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,757,618	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 251,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 259,463	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,339	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,469,508	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 13,032 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number DANVILLE CARE CENTER | STATE OF ILLINOIS # 0032862 | Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 8,163	$		$ 8,163	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,713			6,713	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			7,250			7,250	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				84,810		84,810	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LAB	39-2 39-2					39,421 4,989		39,421 4,989	13
14	TOTAL			$		$ 22,126	$ 129,220		$ 151,346	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 32,996)	945,504		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,695		6
7	Other Prepaid Expenses	8,010		7
8	Accounts Receivable (owners or related parties)	465,322		8
9	Other(specify): R/E TAX ESCROW	223,231		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,675,762	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	862,840		15
16	Equipment, at Historical Cost	590,553		16
17	Accumulated Depreciation (book methods)	(676,321)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 777,072	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,452,834	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 543,195	$	26
27	Officer's Accounts Payable	657,090		27
28	Accounts Payable-Patient Deposits	24,558		28
29	Short-Term Notes Payable	1,017,636		29
30	Accrued Salaries Payable	59,379		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,054		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,083		32
33	Accrued Interest Payable	2,740		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,381,735	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,381,735	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 71,099	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,452,834	$	48

*(See instructions.)

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 690,120	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	421	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 690,541	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(619,442)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (619,442)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 71,099	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,300,344	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,300,344	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,763	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 95,763	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	VENDING COMMISSIONS	3,214	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,214	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,399,354	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,083,213	31
32	Health Care	2,386,059	32
33	General Administration	1,325,211	33
	B. Capital Expense		
34	Ownership	960,237	34
	C. Ancillary Expense		
35	Special Cost Centers	151,346	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,015,566	40
41	**Income before Income Taxes (line 30 minus line 40)****	(616,212)	41
42	**Income Taxes**	(3,230)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (619,442)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 62,679	$ 30.13	1
2	Assistant Director of Nursing	304	304	7,600	25.00	2
3	Registered Nurses	11,053	11,650	276,776	23.76	3
4	Licensed Practical Nurses	18,700	19,844	399,710	20.14	4
5	Nurse Aides & Orderlies	90,091	93,250	891,474	9.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,825	6,223	122,633	19.71	8
9	Activity Director	1,831	1,903	18,332	9.63	9
10	Activity Assistants	6,609	7,127	48,435	6.80	10
11	Social Service Workers	7,329	7,777	107,941	13.88	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,080	25,104	12.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,755	12,589	104,298	8.28	15
16	Dishwashers	13,641	14,132	98,390	6.96	16
17	Maintenance Workers	3,858	3,972	39,630	9.98	17
18	Housekeepers	21,943	22,899	171,071	7.47	18
19	Laundry	15,872	16,604	111,026	6.69	19
20	Administrator	1,940	2,080	62,170	29.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,928	3,360	49,213	14.65	23
24	Clerical	11,138	11,776	133,518	11.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	3,265	3,510	68,880	19.62	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	232,090	243,160	$ 2,798,880 *	$ 11.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	228	$ 9,120	1-3	35
36	Medical Director		8,030	9-3	36
37	Medical Records Consultant	30	1,016	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	2,400	10-3	39
40	Physical Therapy Consultant	16	775	10a-3	40
41	Occupational Therapy Consultant	9	463	10a-3	41
42	Respiratory Therapy Consultant	7	351	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	30	615	11-3	44
45	Social Service Consultant	190	5,894	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	510	$ 28,664		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,305	$ 100,916	10-3	50
51	Licensed Practical Nurses	3,045	117,250	10-3	51
52	Nurse Aides	12	280	10-3	52
53	TOTAL (lines 50 - 52)	5,362	$ 218,446		53

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JAN THOMEN	ADMIN		$ 62,170
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,170

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 60,440
TOTAL (agree to Schedule V, line 17, col. 3)	$ 60,440
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		88,683
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 88,683

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 116,153
Unemployment Compensation Insurance		61,484
FICA Taxes		211,196
Employee Health Insurance		97,239
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		70
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		4,628
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
RELATED PARTY		30,703
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,838
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	2,613
TRUST/FRANCHISE/CONTRIB/ETC	1,525
LICENSES & PERMITS	2,135
DUES & SUBSCRIPTIONS	1,097
MGMT CO ALLOCATION	42
TRUST/FRANCHISE/CONTRIB/ETC	(1,525)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,613)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,112

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,132
Seminar Expense	
	1,577
RELATED PARTY	3,749
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,458

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$ 0		$	$	$	$	$	$	$	$	$
2													
3													
4													
5					N/A								
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC $2,622**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **109,500**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees